The Road from Professionalism to Interprofessionality

A struggle for power that can end up as a new found harmony in health care

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The world is changing rapidly, and today's societal pressures and changes are bound to alter the traditional understanding of professionalism. With Malta's accession to the European Union and with pressing need to reform the Maltese health care system, the health care professions are constrained to adapt to new regulations and standards of health care.

It is opportune to reflect on the origins of health care professions, examine their basic structures and relationships, and agree on a vision for future developments. The medical profession and other allied health care professions have developed under the influence of historical changes and societal forces, such as industrialisation, consumerism, information technology, quality management, demographic changes, and now globalisation. The past five decades have been characterized by a society that has questioned both traditional values and societal structures. All professions, including medicine, have seen their stature diminish, and because of the increasing intrusion by the government, non-medical professionals and the public into health care, the medical profession has lost much of its autonomy and influence throughout the world.[1,2]

These changes have led to the recognition that health care professions need to re-examine their role within modern societies so that they may best serve both individual patients and the community. The superiority that the medical profession had traditionally enjoyed over allied professions has long been challenged and the importance of collaboration and teamwork amongst health care professionals from different disciplines has been recognised by health organisations[3,4]. The stimulus for the development of multi-professional human service organizations originated in the World Health Organization's (WHO) Declaration of Alma Ata in 1978 [5,6], which stated the need for a more holistic approach to healthcare. However, despite the universal recognition of the importance of collaboration and teamwork across different professions, international research in the field has been very limited and implementation in every day practice has been patchy and largely ineffective[7,8].

The medical profession in Malta, like its international counterparts, has not escaped these societal pressures and changes. It has found itself at the crossroads. On one hand, it has to defend its professional status and the public trust it has always enjoyed, and on the other hand, it needs to build up bridges with other emerging health care and social care professions. The importance of the latter as stakeholders in guaranteeing the welfare of society is increasingly being recognised internationally and locally and the medical profession cannot keep overlooking them any longer. In this article, I will consider the perspective of historians and sociologists to discuss how medical professionalism has developed with time and how it can be a barrier to interprofessional practice and the development of collaborative healthcare delivery.

The origins of health professions

For a better understanding of medical professionalism one has to go back to its basics and origins. Doctors fulfil two roles simultaneously, one of a healer and the other of a professional.[9,10] These roles have different origins and traditions. The healer, which is what patients and society require, originated from the Hippocratic tradition.[11]

Professionalism, on the other hand, arose in the guilds and universities of the Middle Ages. In their books, Krause[1] and Elliot[2] have presented a comprehensive account of the origins and development of the professions as exemplified by the medical profession. In the pre-industrial era, health care and social care was provided by members of the families and neighbours, through collaboration and solidarity and with little or no financial reward. In the 1750s, the industrial revolution moved society to a model of competitive capitalism. This economic and philosophical model contributed to the development of the "profession" where the professional group took control of the occupation and created occupational monopoly. Through exclusion, the profession limited the number and type of entrants into its fold, thus enhanced the market value of the service. The profession then began to monitor and regulate the labour of other occupations that provide related services to protect its market niche[1].

During the industrial revolution, the medical profession established itself as the desired purveyor of care. Cures of the traditional healers and midwives were discredited. In 1858, Britain passed the Medical Registration Act, which required medical practitioners to pass examinations before practicing medicine. Only middle and upper class men could access university education. They had significant resources and enjoyed the gender privilege of the patriarchal society; consequently, wealthy men dominated the medical profession.[1]

In the 19th century, women's roles were within their homes, with their children and as servants of men. As women entered the work force in the latter decades of the 19th century, they were encouraged to go into nursing as it embraced the virtues of true womanhood. Nurses became the doctors' helpers. As more formal nursing education became available, only women of families with money could afford to consider the training. The organisation of medicine itself has traditionally reflected the values of the middle and upper classes, with the delivery of care being organized around the needs and desires of health care professionals, particularly doctors. Only recently, there are moves to organise the delivery of care around the needs and desires of patients and families.

Historians and sociologists of medicine have spent a great deal of energy examining medical professionalisation. In his essay, S.E.D. Shortt[12] argued that doctors used the language of science to boost their social status and authority before the discovery of scientific cures for diseases. In the drive for consolidation of professional authority, doctors in the nineteenth century sought to exert control over all associated occupations, and subjugate allied occupations such as nursing, radiography, physical therapy and pharmacists.[13,14] Doctors wanted to function without the interference of others in the health industry. In addition, doctors sought to enforce a power structure that placed them on top of other health care occupations.[15] The ongoing struggle amongst health care professionals, together with external factors and internal exigencies shaped the identity of all health care occupational groups.

By the end of the nineteenth century, bacteriological, pharmacological and physiological discoveries changed the nature of medical knowledge and authority. There was a shift from the rhetoric of good character and moral education, to the scientific knowledge required to cure diseases. Increasingly, competence in scientific education, rather than liberal arts defined the capabilities of the practitioners. Pharmacists benefited from this change, since they defined their expertise in pharmacology and chemistry and built their authority on these disciplines. They managed to stave off the encroachment by doctors' authority, building pharmaceutical credibility and with it social and cultural authority.[16] However, other health care occupations failed to benefit from the new scientific knowledge and remained dominated by the medical profession for the greater part of the twentieth century. Therefore, struggle for authority and social status, gender and social class issues have been factors in the friction and conflict that has existed between health care professions until the present day.

Recent developments in medical professionalism

During the last century, the medical profession has experienced shifts in its status according to the level of public expectation and trust. From the early 1900s until the 1950s, the literature was supportive of the concept of professionalism and it was felt that the service orientation of the medical professional would benefit society.[17-22] The concept of professionalism came under intense scrutiny and criticism during the 1960s and 1970s. The belief that doctors would be altruistic was greeted with scepticism by social scientists, politicians, and the inquisitive public. The medical profession was criticised for its emphasis on remuneration, its failure to self regulate adequately, its inability to address problems, and the fact that the profession often puts its own welfare above that of both society and individual patients.[23-29] This occurred as the governments, the private sector, and non-medical professions took control of the health care services throughout the world.[1]

Since the late 1980s, there has been a reverse in the opinion of the social scientists and the general public, most being supportive of the concept of medical professionalism.[30-33] This transition in public trust in the medical profession has partly stemmed from the fact that initially the medical profession had been blamed for defects and deficiencies in the health care systems. With the diminishing influence of the medical profession on public policy, the blame has shifted to those primarily responsible, the government, managers and health planners. During the last decade, medical professionalism as a concept appears to have regained public respect.[30,31] However, the medical profession to remain respectable must meet contemporary requirements, must be understood by both the medical profession and society, and must be responsive to public expectations and needs.

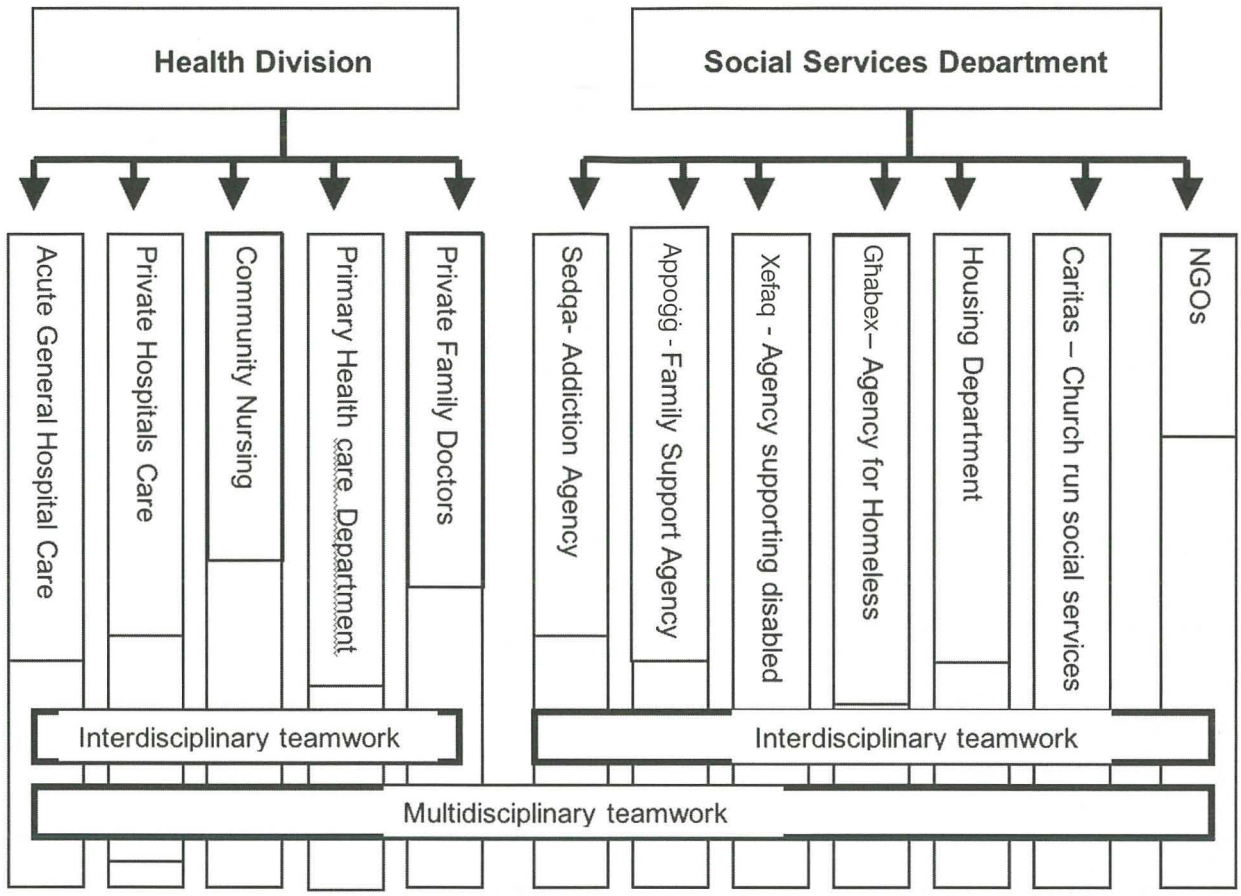
With the British ruling Malta from 1815 to 1964, and with the on going close relationship between Maltese professional associations and Royal medical and nursing colleges, meant that the above evolution of British health care professions, historic reflections, conflict and strain between professions, had similarly shaped the history of the Maltese health care professions.[34]

Professionalism today

During the latter half of the twentieth century, a renewed interest in and better understanding of professionalism gave rise to accelerated process of "professionalisation".[35] There was a general trend whereby health care and social care disciplines and occupations started gaining their autonomy and professional status. Different health care occupations have evolved their own culture; each has struggled to define its identity, values, sphere of practice and role in patient care. This has led each health care profession to work within its own niche to ensure its members have common experiences, values, approaches to problem-solving, language, and occupational identity.

Cognitive learning theory suggests that each profession may attract a predominance of individuals with a particular set of

Figure 1. Vertical flow of knowledge (top down) within organisations compared with sideways flow of knowledge across organizations. The two models represent the old compared to the new model of teamwork in health and social care.



cognitive learning skills and styles.[36] According to educational theories and psychological theories,[37] each professional school will use methods best suited to its learners, which will further reinforce the walls of the niche. The differences in learning environments for nurses and medical students may also reflect the homogeneity of the culture within each profession. Physicians traditionally learn independently in a highly competitive academic environment, while nurses learn in a more protected environment as part of teams, collectively working out problems and efficiently exchanging information across shifts. Petrie[38] suggests that each profession has a different "cognitive map". The cognitive map develops as a consequence of the educational and socialization experiences of the students of each profession, built on each student's own unique cognitive and constitutional make-up. This map is a major component of the culture of each profession.

As a result of historic development, tradition, and cognitive selection, the different professions are divided amongst themselves by several important issues, such as gender differences, differences in educational and training paths, professional philosophy, profession autonomy and regulation, differences in salary scales and professional fees, social and professional status and power.[13] These differences compromise the establishment of interprofessional teamwork in health and social care sectors.[38] All strive to achieve improvement in patients' wellbeing; nevertheless, there is a tangible but undeclared struggle of power amongst the different care providers.[10]

Being part of a multidisciplinary team, create internal issues that may pose different challenges.[39] The different personnel have different personalities and come from different environment; hence collaboration, cooperation and mutual agreement are not easily and always reached. Little experience and guidance exists on how to achieve these. Finding equilibrium of power is not an easy task that can be achieved overnight. Training in interprofessional teamwork should start at the educational institutes, first and foremost.

New model of care delivery - Interprofessional teamwork

Human health and illness depends on several complex, adaptive and interacting systems which may have physical, psychological, social, and spiritual dimensions.[40-43] For this reason no single profession can ever hold all the expertise required to provide solutions to the diverse problems that present in clinical setting.[44] Providing appropriate levels of care for individuals with chronic or acute conditions and social problems has become increasingly complex and expensive. Acute care calls upon the latest technology and medical expertise for relatively short time periods

in in-patient facilities. In contrast, chronic conditions often require care in the community which integrates health care, social care and rehabilitation (figure 1). But provision of these types of care is complicated by the pressures on funders and health planners who must allocate scarce resources between chronic health care, acute health care and social care needs.[45-47] Furthermore, difficulties in health and social care provision arises when it occurs across agency, and organisational and professional boundaries, necessitating coordination and collaboration among different groups.

Since the mid-1990s, the Maltese Government has sought to deal with these issues by establishing new health and social care agencies. However, while much effort has gone into establishing and developing these agencies, integration of care (seamless) for service users has not been achieved. Malta needs an effective health care system that is more rooted in partnership and collaboration between the different sectors and agencies, rather than competition amongst service providers, managed at departmental level. [48-50] The emphasis on integrating care will require the establishment of interdisciplinary teams.[51] This can be exemplified by the transformation of community based solo practitioners into primary care groups based on partnership, collaboration and co-ordination amongst professionals and across organizational boundaries, and consisting of family GPs, nurses, social workers, pharmacists and supporting staff.[52] Team approach to patient care can help to build staff morale, improve professional status, and create improvements and efficiency.[53] However, this cannot be achieved overnight and a lot of effort and planning is required.

It is being recognised that to provide holistic and integrated care, there must be a move from illness-centred care to patient-centred care.[54-56] Patient-centeredness entails shared responsibility in health and social care;[57] a shift from the 'paternalistic' model [58,59] towards a greater respect for patients' needs and wishes.[60] To make patient-centeredness work, service providers need to move away from traditionally and professionally defined roles and boundaries to new roles defined by patients' needs.[61,62] For example, joint clinics or joint home visits by a doctor, a nurse, and a social worker is something new in local health care system, that can bring better understanding of patients' needs as well as mutual support and understanding of the service providers themselves. However, for such approach to be implemented on a large scale, restructuring of health care organisation and much training of service providers are required.

Recommendations

The history of professional cultures has traditionally fostered a hierarchical power structure, with the doctors in control.[63] However, the power and authority of this hierarchy is challenged by the interprofessional teamwork practices.[64] The environment for collaborative practice must foster a level status basis amongst the various team members of diverse professional background.[63] In collaborative practice, individual team members assume profession-specific roles, but as a team, they identify and analyze

problems, define goals and assume joint responsibility for actions and interventions to accomplish the goals.[65] To interact meaningfully with each other and with the patient and/or family, team members must be familiar with the expertise and roles of the others team members.[66] Given the lack of common education and interprofessional experience, this poses a real challenge to practicing teams.

If the interprofesstional model of teamwork is to be incorporated into the new health care system for Malta, than as part of the health care reform, health care providers, either as learners in basic training or as learners in continuing professional development, need to be taught new and modern skills in order to be able to explore, understand, and accept his/her fellow team members' cognitive maps. These skills include the ability to recognise the challenges inherent not only in group dynamics, but in trying to blend the different professional cultures represented in the team. Individual personalities and characteristics also contribute to the team dynamics, often blurring the issues of professional conflict with personal ones.

The development of the following collaborative skills are essential for effective interprofessional teamwork in practice:[67]

1. **Cooperation**: Acknowledging and respecting other opinions and viewpoints while maintaining the willingness to examine and change personal beliefs and perspectives.
2. **Assertiveness**: Supporting one's own viewpoint with confidence.
3. **Responsibility**: Accepting and sharing responsibilities, and participating in group decision-making and planning.
4. **Communication**: Effective sharing of important information and exchanging of ideas and discussion. Communication skills that are taught to students usually focus on interactions with patients and families from the perspective of his/ her profession, not on communication across professions.
5. **Coordination and leadership**: Leadership skills are required to manage an interprofessional team and for efficient organisation of group tasks and assignments.

Doctors in particular are trained to take charge, and assume a role of leadership in many settings. For them, learning to share leadership in an interprofessional team setting is a challenge, as they may assume, or be expected by other team members, to take on the responsibility of the leadership role. However, members of other professions are also being trained to take decisions and assume responsibility for their decisions.

Conclusions

Although interprofessional teamwork may provide solutions to effective health care and social care system, such approach is very new in Malta and cannot be easily established. Teamwork is still not easily accepted by the different professions and organisations and the changes it entails are strongly resisted by the stakeholders. Upto now, it can be observed that the different professions have developed a relationship build on mutual tolerance rather than mutual acceptance and understanding. Ground work for interprofessional teamwork can be initiated at educational and training institutions by introducing it into professional curricula, where it can be openly discussed and practiced. In practice, interprofessional teamwork can only be tried amongst a few, selected and willing service providers, who are ready to face and resolve the many challenges that exist.

The responsibility lies in the hands of the health authorities, health planners and professional associations to recognise the benefits of developing future Maltese health care system on interprofesstional team practices. The new Health Services Act, expected to be enacted in parliament over the coming months[68] should promote a legal framework for the public and private health sector based on the model of interprofessional teamwork. Opportunities should be identified, and resources allocated so that pilot interprofesstional teams, led by a few enthusiastic and energetic champions who are not afraid of innovations and are ready to overcome institutional and cultural barriers, start forming in Malta.

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